Washington State Department of Social & Health Services

PHYSICAL EVALUATION

Please refer to the Provider Handbook and WAC 388-448-0020 and 0030 for more information.

1. Clients are not eligible for any medical or cash assistance until we receive clear, objective medical documentation. Please return the information as soon as possible.
2. Payment for a general or comprehensive physical evaluation requires attachment of any **chart notes** for last six months, medical facts about the client's functional capacity and supporting evidence such as Range of Motion studies, laboratory, pathology or imaging results. The Medical Evidence Request, DSHS 14-150, is your authorization for payment for services. A bill for services must accompany this evaluation.
3. As you examine this patient, please evaluate all medical conditions that may limit the ability to work (functional capacity). You are not limited to evaluating the presenting problem(s).
4. Please list each diagnosis separately and assign one rating of severity for each diagnosis. We will use information from this report along with education and work history to decide whether the client is employable and meets Washington State general assistance incapacity criteria.
5. Include recommended treatment plan and information about mental health issues and substance abuse if known.
6. **Confidentiality:** The information you provide is subject to Washington State Public Disclosure laws and may be released to the client upon request. Information will remain confidential under state law and DSHS discloses no further information without the written consent of the individual to whom it pertains or as otherwise permitted by state law.
7. **Reminder:**
   - ?? Include the date of your examination, your address and telephone number.
   - ?? Advanced Registered Nurse Practitioners (ARNP) need to indicate their area of advanced training.
   - ?? The supervising physician must co-sign reports completed by their Physician Assistant.

A. CLIENT IDENTIFICATION

NAME	BIRTH DATE	CLIENT IDENTIFICATION NUMBER

CHIEF COMPLAINTS AND SYMPTOMS

B. AUTHORIZATION TO RELEASE INFORMATION

I authorize _____ to release to the Department of Social and Health Services (DSHS)

EXAMINING PROFESSIONALS NAME

the following information regarding my condition, solely to evaluate eligibility for public assistance. This release includes diagnostic testing or treatment information concerning mental health, alcohol or drug abuse, sickle cell disease, and results of Sexually Transmitted Diseases (STD), including HIV/AIDS [Revised Code of Washington (RCW) 70.24.105].

This authorization is valid for one year or until _____ (date or event).

I may revoke or withdraw this authorization at any time in writing, but that will not affect any information already shared.

I understand that the information provided to DSHS may be re-disclosed only with a valid authorization from me or if required by law.

CLIENT'S SIGNATURE	DATE

C. HISTORY

Date of onset of primary impairment: _____

Describe any treatment to date including any hospitalizations:

Describe any response to treatment:

Is there a current indication or history of alcohol or drug abuse? ☐ Yes ☐ No

D. EXAMINATION RESULTS

Instructions: Describe physical examination findings and attach chart notes with lab, pathology and imaging reports

Height _____ Weight _____ Blood Pressure _____ Respiratory Rate _____

CHECK IF WITHIN NORMAL LIMITS (WNL)	IF NOT WNL, DESCRIBE ANY ABNORMAL FINDINGS
☐ Skin	
☐ ENT	
☐ Cardio-Vascular	
☐ Pulmonary	
☐ Abdomen	
☐ Shoulders/upper extremities	
☐ Back (thoracic-lumbo-sacral spine)	
☐ Hips/lower extremities	
☐ Gait and station	
☐ Neurological	(Include any weakness, + Romberg, ataxia, sensory deficit, and/or DTRs)

Describe any signs or proof of limits on agility, mobility, or flexibility or non-exertional environmental/workplace restrictions (such as visual, hearing or pulmonary restrictions).

Laboratory/diagnostic/ROM studies results (attach reports):

List any additional tests or consultations needed:

Is it reasonable to expect the diagnosed medical condition to produce the reported symptoms? ☐ Yes ☐ No

E. ASSESSMENT

1. List each diagnosis in Column 1 below.
2. In Column 2 below estimate the degree of interference with the client's ability to perform the basic work-related activities of **(a) sitting, (b) standing, (c) walking, (d) lifting, (e) handling, (f) carrying, (g) seeing, (h) hearing, (i) communicating, and (j) understanding or following directions.**
3. In Column 3 below, estimate the severity of the diagnosis using the following definitions.

RATING	SEVERITY	DEFINITION
1	None	No interference with the ability to perform basic work-related activities
2	Mild	No significant interference with the ability to perform basic work-related activities
3	Moderate	Significant interference with the ability to perform one or more basic work-related activities
4	Marked	Very significant interference with the ability to perform one or more basic work-related activities
5	Severe	Inability to perform one or more basic work-related activities

1. DIAGNOSIS	2. AFFECTED WORK ACTIVITIES (See (a) – (j) above)	3. SEVERITY RATING

Check any of the following areas that has restricted mobility, agility or flexibility: ☐ balancing, ☐ bending, ☐ climbing, ☐ crouching, ☐ handling, ☐ kneeling, ☐ pulling, ☐ pushing, ☐ reaching, ☐ sitting, and ☐ stooping.

Describe any restrictions:

Using the definitions below, what is the client's overall work level? _____

Definitions of Work Levels

Heavy work means the ability to lift 100 pounds maximum and frequently* lift and/or carry up to 50 pounds.

Medium work means the ability to lift 50 pounds maximum and frequently* lift and/or carry up to 25 pounds.

Light work means the ability to lift 20 pounds maximum and frequently* lift and/or carry up to 10 pounds. Even though the weight lifted may be negligible, light work may require walking or standing up to six (6) out of eight hours per day, or involve sitting most of the time with occasional** pushing and pulling of arm and/or leg controls.

Sedentary work means the ability to lift 10 pounds maximum and frequently* lift and/or carry such articles as files and small tools. A sedentary job may require sitting, walking and standing for brief periods.

Severely limited means unable to lift at least 2 pounds or unable to stand and/or walk.

***** Frequently means the person is able to perform the function for 2.5 to six (6) hours in an eight-hour day. It is not necessary that performance be continuous.

****** Occasional means the person is able to perform the function from very little up to 2.5 hours of an eight-hour day. It is not necessary that performance be continuous.

E. ASSESSMENT (CONTINUED)

List each diagnosis that is probably caused or aggravated by alcohol or drug abuse:

Is alcohol/drug treatment recommended? ☐ Yes ☐ No

List each diagnosis where level of work would increase with 60 days of abstinence:

How long do you estimate the current, overall limitations on work activities will continue without medical treatment?

☐ At least 12 months

☐ 90 days to 12 months. Number of months: _____

☐ Less than 90 days. Number of days: _____

F. PLAN

1. What treatment is recommended to improve employability?

2. Is the client able to participate in pre-employment activities such as job search or employment classes?
   ☐ Yes ☐ No Explain in comments below.
3. Is this the client's first visit with you? ☐ Yes ☐ No; if no, how long have you attended this client? _____
4. Will you be providing ongoing care? ☐ Yes ☐ No
5. Once the client has received recommended treatment, how soon should the ability to work be re-evaluated?

G. COMMENTS

The information you provide is subject to Washington State Public Disclosure laws and may be released to the individual upon his or her request. All information disclosed from your records will remain confidential under state law and DSHS discloses no further information without the written consent of the person to whom it pertains, or as otherwise permitted by state law.

RETURN THIS REPORT TO:	PRINT NAME OF EXAMINING PROFESSIONAL	EXAMINATION DATE
	SPECIALTY AREA/ADVANCED TRAINING	TELEPHONE NUMBER
WORKER SIGNATURE DATE	STREET ADDRESS CITY STATE ZIP CODE	
TELEPHONE NUMBER	EXAMINING PROFESSIONAL'S SIGNATURE/TITLE DATE	
FAX NUMBER	RELEASING AUTHORITY/SUPERVISING PROFESSIONAL'S SIGNATURE DATE	